

STAR + PLUS Responses to Questions from CMS

Program Comments

1. Page 4 – Block 3 of the preprint was not checked – STAR+PLUS includes a FFS Primary Care Case Management delivery system. Because the State used the Renewal Preprint for Capitated Waivers to submit the renewal application, there is no information provided on the PCCM program. The State needs to check block 3 and include the cost-effectiveness section of the FFS PCCM waiver preprint. In addition to checking the appropriate items on the preprint, the State needs to provide a brief narrative description of the PCCM program.

Page 4 was corrected and a description of the PCCM program was added. We will send the PCCM waiver preprint cost-effectiveness section to you on Monday, September 16, 2002.

2. Page 5 – Unlimited inpatient services/30day spell of illness limitation –This is listed as an additional service to be provided under the waiver. However, the State indicates that this option has not been available since December 1999. Since the State is not incurring additional costs for lifting the 30 days spell of illness limitation for inpatient hospitalization, ask the State to explain why this service is still listed as an additional service to be paid for with a portion of its savings.

An error was made on the original submittal, which has been corrected. A revised page 5 is attached.

3. Independent Assessment: How does the State plan to address recommendations made in the independent assessment regarding the following:

Page 24 – the issue raised regarding higher emergency room utilization.

The State and the STAR+PLUS MCOs have been aware of the ER use remaining high in Medicaid Managed Care. Part of the explanation is the prudent layperson definition has led to payment of all ER charges whether or not criteria are met. The MCOs claim that it is too time intensive and costly to review ER medical records on questionable visits. The MCOs send letters to members who utilize the ER during regular office hours and copy the PCP. MCO care coordinators call non-compliant members to promote visits to the PCP office. In discussions with the MCOs, we learned that their efforts have met with limited success. In addition to the MCO efforts, the State has convened a workgroup, chaired by the Medicaid/CHIP Medical Director, to identify possible actions to address this issue.

Page 26 – issue with member education and coordination of care relating to transition between plans and/or care coordinators

During the time when ACCESS, and a year later ACCESS+PLUS (UTMB,) were transitioning out of the program, there was a lot of confusion for members, particularly those with a LTC service plan. The State's STARline (managed care helpline) and MAXIMUS (enrollment broker) were asked to assist members with transition issues.

Also, Amerigroup and HMO Blue have added additional care coordinators in response to new membership. We continue to monitor and evaluate member education and care coordination efforts by the plans.

Page 27 - quality improvement for people receiving treatment for depression or diabetes

Independent Assessment recommendations reiterated the recommendations made by the STAR+PLUS EQRO on two focused studies conducted during the previous waiver period: "...improve PCP documentation rates of treatment and outcomes; continue studying outcomes of care; and track the impact of improvement efforts on treatment and documentation."

Based on the experiences of the previous depression studies, a quality improvement model has been developed that includes, enhanced care coordination, a non-intrusive registration system, and improved communication between PCPs and behavioral health practitioners. The State is currently seeking a private grant to fund the implementation of this model in the STAR+PLUS program.

The previous diabetes focused studies were instrumental in establishing baseline data for service outcomes. The results of these studies were, and continue to be, utilized by the HMOs to establish provider compliance with nationally recognized guidelines, identify opportunities for member/provider education, & evaluate improvement in outcomes during re-measurement.

During the upcoming waiver period the State will conduct an additional biennial study in depression and an, as yet unspecified, focused study regarding treatment and outcome.

4. Page 33 – Services Chart – Although unlimited inpatient services is listed in item g.2 on page 5 as an additional service to be provided under the waiver, this service is not included under the column headed 1915(b)(3) Waiver Services. Please explain.

This service was added to the bottom of the table on item g.2 on page 5.

5. Page 35, item 4 – Other Services To Which Enrollee Can Self-Refer – Item 4 is for the purposes of identifying services in addition to emergency care and family planning that enrollees can access without prior authorization. However, the language in the second bullet restricts family planning services by limiting self-referral to network providers. Requiring prior authorization and the use of network providers for family planning services are prohibited under the waiver. Furthermore, item 3(b)(i) of the preprint states that the MCO is required to reimburse non-network family planning services. Please resolve this discrepancy.

This response was corrected to indicate members can access any provider for family planning services.

6. Page 38, item (c) – Immunizations – The discussion in Attachment 4 only includes information about the surveys that were conducted to determine whether children 3 through 24 months of age had received up to date immunizations and the immunization rate for 2000. It did not state what activities Texas has initiated to improve immunization rates for enrollees under the waiver.

Information regarding the State's initiatives to improve the immunization rates was added to the waiver response on page 38.

7. Page 52 – Monitoring Capacity Standards – The State explains how it monitors MCO capacity, but did not describe the results of this monitoring.

Information regarding the results on the State's monitoring of provider capacity was added on page 52.

8. Page 55 – Provider Chart - Number of Providers in Current Waiver Chart – The State included the number of PCPs in each plan, but did not give a breakout of these numbers by provider type (i.e., family practice, internal medicine, OB/GYN, pediatricians).

Tables were added showing the breakout of the provider specialties as attachment 15 to the waiver.

9. Page 57, item 3 – PCP Capacity Standards – Rural Health Clinics are listed as a type of provider that can serve as a PCP. However, on page 3, item a(ii), this service is not checked as one of the services the MCO is at risk for providing to its enrollees. Also, column 4 of the chart on page 32 is marked “N/A” which indicates that this service is not included in the capitation rate paid to the MCOs. Please explain.

An explanation was added on page 57 clarifying that Harris County does not have any Rural Health Clinics.

10. Page 60, item b – Capacity Monitoring – The State explains how it monitors MCO capacity, but did not include the results from capacity monitoring for the prior two-year waiver period.

A response was added on page 61 acknowledging the results of the State's capacity monitoring.

11. Page 111, item b – Fraud and Abuse – The State did not provide summary results from its fraud and abuse monitoring activities for the previous waiver period. The information provided in this section only explains that the State requires the MCOs to develop fraud and abuse compliance plans, including policies and procedures to detect, investigate and report potentially fraudulent or abusive situations.

The State added a clarification on page 112. There were only two fraud and abuse referrals during the last contract period. We do not have the results of those formal investigations.

12. Page 112, item c – Fraud and Abuse -This item requests that the State provide a copy of its formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in managed care, which should identify the staff, systems, and other resources devoted to this effort. I did not find this information in the material that was submitted by the State.

A copy of the formal fraud and abuse plan was added as attachment 16.

13. Page 140 – Children With Special Health Care Needs – There is language in the first paragraph that indicates enrollees can access HIV diagnosis services without prior authorization or referral by a PCP. However, this service is not included on page 35, under item 4 (Other Services to Which Enrollee Can Self-Refer).

This language has been deleted from page 143 of the waiver, as this is not a STAR+PLUS contract requirement.

14. On page 154 (i) in the STAR + Plus renewal, the state says the MCO is required to acknowledge receipt of each complaint and grievance **within 10 days**. That's what they said previously also. Why didn't they use **5 days** because that's the timeframe the State used in the STAR consolidated waiver; that's the timeframe they use on the web when describing the member complaint process, and that's the timeframe used by HMO Blue and Amerigroup in their STAR + Plus member handbooks.

This reference was incorrect, and was corrected on page 153 to state 5 days.

15. Page 161, item b.6 – Information provided by the MCO – The State failed to check this block which requires the MCO to disclose to enrollees on an annual basis their right to adequate and timely information related to physician incentives. This is a required item for MCOs.

The omission of a check on page 160, item b.6 was an oversight. The STAR+PLUS Plans include a notice regarding physician incentive plans (or lack of) in their new member material and in annually in their quarterly member newsletters. This requirement is also addressed in the STAR+PLUS contract.

Cost Effectiveness Comments

1. Please explain how the vendor drug cost rates were developed. Please explain trending factors used to project drug costs.

Where were the PMPM prescription costs (with and without waiver) used in Appendix D.X derived? They don't appear to match those in Appendix D.XI. Were costs of prescriptions for dual eligibles included in the calculations Appendix D.XI ?

In Appendix DX, in Year One, the State applies "without waiver" vendor drug cost rate of \$138.67 to 54,791 enrollees (dual eligibles, Medicaid only, and PCCM enrollees). On the "with waiver" side, the State shows vendor drug cost rate of \$155.94 in Year One, but only applies these costs to 19,043 enrollees. Why doesn't the table report prescription drug costs for the remaining enrollees? If the cost for the remaining 35,748 enrollees is \$138.67, then the overall waiver savings is much less. (It would be \$6,829,675 for Years 1 and 2, rather than the reported \$122,627,191.)

On the attached new cost-effectiveness spreadsheet, the corrected information on vendor drugs is included under the Rx tab.

2. Page 94 – The assurance block must be initialed or checked.

This block has been checked in the waiver.

3. Page 108, item b – 1915(b)(3) Waiver – Page 5, item g.2 lists annual adult well checks and unlimited inpatient services as additional services to be provided under the waiver. However, the language here states that "No additional costs are incurred for the annual adult well checks or for lifting the 30 day spell of illness limitation for inpatient hospitalization." The State should check Box 2 on page 109, and provide the required information if the State is requiring plans to spend a portion of their capitated rate on additional non-State plan medical services.

Block 2 has been checked to indicate that the State plans to spend a portion of the capitation rate on additional services, and the amount of those services has been indicated.

4. Appendix DX.III. - The State did not use the UPLs approved in the current waiver to determine the without waiver costs for years 1 & 2. However, after performing calculations to compare the cap rates paid to the MCOs for years 1 & 2 of the waiver to the approved UPLs for Waiver Years 1 & 2, this becomes a moot point. The composite cap rates for year 1 (\$383.94) and year 2 (\$381.04) do not exceed the approved composite UPLs (\$410.55 and \$418.39). In fact, the composite of the PMPM Without Waiver costs that the State used in its without waiver development for years 1 & 2 (\$400.42 and \$388.43) are also less than the approved composite UPLs. Why did the State recalculate the UPLs?

As discussed in our conference call with CMS, the UPL was recalculated because the waiver period changed. The first waiver period started February 1, 1998, and this was changed in the last waiver to correspond with the state fiscal year.

5. Appendices D.VI. through D.IX, CBA-MM (Dual eligibles) and OCC-MM (Dual Eligibles) – It appears the Long-term Care/Total Expense for Waiver Years 1 and 2 on both of the appendices have been switched. State needs to correct. Also, the CBA-MM Year 1 and 2 Long-term care/Total PMPM and expenses do not match those in Appendix D.V.

These appendices have been corrected.

6. Appendices D.VI. through D.IX – The State should explain how the “Annualized Increase Factors” for Price, Utilization and Policy (without waiver) were determined.

It is not possible to separate the increases due to price utilization and policy because of the changes in the relationships in the risk groups. After STAR+PLUS was implemented there were changes in utilization patterns, and the risk groups were revised to reflect those changes. The consequence of this was that some risk groups saw large increases, while others showed small increases, or even decreases during the rate setting process.

7. Appendices D.VI. through D.IX, (Derivation of Capitation Rates) page 4 – 8 (Waiver Year 2) and page 6 – 8 (Wavier Year 3) – Summary of Increases – The increase in the capitation rates shown for the OCC-Medicaid-only and Medicare/Medicaid risk groups for LTC are higher for Waiver Years 2 (50.27% and 21.30%) and 3 (22.40 % and 14.06%) in comparison to the increase for the CBA risk groups. The State should explain the higher percentages.

See response under number 6 to explain the higher percentage change to certain risk groups.

8. At the time of the current waiver approval, the State projected cost savings of \$1,832,815; and in this waiver renewal the State calculated a savings of \$122,627,191* for the same period. What factors caused the State to save so much more than projected? (*total savings may be much less if vendor drug “with waiver” calculations are incorrect.)

The error in the previous cost savings projection was due to an error in the vendor drug cost calculation.

9. We would like the State to provide a brief written explanation of their rate setting methodology.

The brief explanation of the rate setting methodology is included under the rate tab in the attached spreadsheet.